STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155780	A. Building B. Wing	03/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Homestead Healthcare Center	7465 Madison Ave Indianapolis, IN 46227

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 44849 Based on interview and record review, the facility failed to ensure an accurate Minimum Data Set (MDS) assessment was completed for for 1 of 21 residents reviewed. An indwelling urinary catheter was not coded on the MDS assessment. (Resident B) Finding includes: The clinical record for Resident B was reviewed on 3/9/22 at 11:22 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disorder and neurogenic bladder. The Admission MDS assessment, dated 1/1/22, indicated Resident B was cognitively intact and did not have an indwelling urinary catheter. An Initial Admission Evaluation, dated 12/27/21 at 6:26 p.m., indicated Resident B had a 14f (size) indwelling Foley (urinary) catheter that was draining clear urine. A Nurse Practitioner Progress Note, dated 1/13/22 at 2:08 P.M., indicated .Resident B had an indwelling Foley catheter and the catheter had been removed three days prior due to irritation. During an interview on 3/14/22 at 8:47 A.M. The MDS Coordinator indicated she was not aware Resident B had an indwelling urinary catheter because there were no orders entered into the electronic medical record. The indwelling urinary catheter should have been documented on the Admission MDS assessment. On 3/21/22 at 3:20 P.M., the facility was unable to provide a policy regarding MDS assessment accuracy by survey exit. This Federal tag relates to Complaint IN00374538. 3.1-31(d)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 39131 Based on interview and record review, the facility failed to develop a person centered care plan for a resident that receives narcotic medications for 1 of 21 residents reviewed for care plans. (Resident 6) Finding includes1 The clinical record for Resident 6 was reviewed on 3/15/22 at 1:45 p.m. The diagnosis included, but were not limited to, bilateral above the knee amputations and chronic pain syndrome. The Physician's Orders included, but were not limited to: Hydrocodone-acetaminophen (narcotic pain medication), 10-325 milligrams (mg), one tablet every 4 hours, as needed for pain, ordered 3/7/22. Resident 6's clinical record lacked a plan of care for the monitoring of narcotic pain medication side effects such as drowsiness, confusion, sedation, lethargy, constipation, and respiratory depression. During an interview on 3/21/22 at 1:30 p.m., the DON indicated Resident 6's care plan did not include the monitoring of narcotic pain medication side effects. On 3/21/22 at 1:30 p.m., the DON provided a policy, dated 5/30/19, titled: Plan of Care Overview, and indicated it was the current policy in use by the facility. A review of the policy indicated, .The plan of care .is the written treatment provided for a resident that is resident-focused and provides for optimal personalized care .it is the policy of this facility to provide resident centered care that meets the psychosocial, physical, and emotional needs and concerns of the residents. Safety is a primary concern for our residents, staff, and visitors. 3.1-35(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 38466 Based on observation, interview, and record review, the facility failed to ensure ADL (Activities of Daily Living) care was provided for a dependent resident who required assistance with bowel and bladder incontinence care for 1 of 3 residents reviewed for ADL care. (Resident M) Finding includes: During a tour of the facility from 3/10/22 at 10:15 a.m. to 10:20 a.m., a strong urine odor was noticed in the hallway near Resident M's room. Resident M's bed was observed to have a blanket and fitted sheet resting on the mattress. A large brownish colored wet area was observed to have soaked through the blanket, fitted sheet, and onto the mattress. The wet area covered approximately 1/3 of the mattress. On 3/10/22 from 12:09 p.m. to 12:15 p.m., Resident M's bed was observed to have a blanket and fitted sheet resting on the mattress. A large brownish colored wet area was observed to have soaked through the blanket, fitted sheet, and onto the mattress. The wet area covered approximately 1/3 of the mattress. On 3/10/22 at 2:30 p.m., Resident M's bed linens were observed to be clean and no odor noted. During an interview at that time, Resident M indicated staff just changed the sheets a few minutes ago. On 3/12/22 from 9:32 a.m. to 9:40 a.m., a strong urine odor was noticed in the hallway near Resident M's room. Resident M was observed sleeping on his bed. The bed's bottom sheet, which the resident was resting on, was observed to have a brownish yellow wet stain in the middle of the sheet. On 3/12/22 at 11:55 a.m., Resident M's bed was observed. The bottom sheet was observed to have a brownish yellow wet stain. The stained area was approximately 5 inches from the head-board area of the bed to the middle section of the mattress area. Resident M's pillow, located at the head-board area of the bed, was laying on top of the brownish yellow wet stained bottom sheet. On 3/17/22 at 11:38 a.m., Resident M's clinical record was reviewed. The diagnoses included, but were not limited to, benign prostatic hyperplasia with lower urinary tract symptoms (enlarged prostate gland that can cause urination difficulty) and vascular dementia. The Quarterly Minimum Data Set (MDS) assessment, date 2/11/22, indicated Resident M was mildly cognitively impaired, frequently incontinent, and required assistance with hygiene and toileting. Resident M's care plan, initiated on 12/23/21 and valid through 4/4/22, indicated assistance was required for ADLs, .Resident requires supervision to total assistance with hygiene .Resident requires supervision to total assistance with toileting . During an interview on 3/21/22 at 10:40 a.m., Resident M indicated he wore an incontinence brief because of not being able to hold his urine and that staff didn't always change his brief when needed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/21/22 at 10:45 a.m., CNA 9 indicated Resident M was incontinent of bowel and bladder. The resident wore an incontinent brief, was checked every 2 hours, and more often as needed for incontinence care. During an interview on 3/21/22 at 11:04 a.m., the DON indicated staff were to monitor Resident M every two hours and more often as needed for toileting care. On 3/21/22 at 8:20 a.m., the DON provided a copy of the Routine Resident Care policy, dated 4/6/16, and indicated it was the current policy in use by the facility. A review of the policy indicated, .provide routine daily care by a certified nursing assistant with specialized training in rehabilitation/restorative care under the supervision of a licensed nurse including but not limited to .toileting, providing care for incontinence with dignity and maintaining skin integrity . 3.1-38(a)(3)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 44849 A. Based on interview and record review, the facility failed to ensure a physician order was followed for transferring a resident to the hospital. Two days later the resident was found unresponsive for 1 of 3 residents reviewed for hospital transfers. (Resident B) This deficient practice resulted in an Immediate Jeopardy. The Immediate Jeopardy began on, 1/11/22 at approximately 2:32 p.m., when the facility failed to follow a physician's order to send a resident to the hospital. Two days later the resident was found unresponsive. The Administrator, Director of Nursing, and the Regional Director of Nursing were notified of the Immediate Jeopardy on 3/11/22 at 5:00 p.m. The Immediate Jeopardy was removed on 3/16/22 at 4:05 p.m., but noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. B. Based on interview and record review, the facility failed to ensure medication for reversal of low blood sugar was available and given per nursing measures to treat an acute episode of hypoglycemia resulting in hospitalization for 1 of 3 residents reviewed for diabetic care. (Resident C) This deficient practice resulted in an Immediate Jeopardy. The Immediate Jeopardy began on 2/22/22 at approximately 8:50 a.m., when the facility failed to provided glucagon as a nursing measure to treat a hypoglycemic episode. The resident was sent emergently to the emergency room . The Administrator, Director of Nursing, and the Regional Director of Nursing were notified of the Immediate Jeopardy on 3/11/22 at 5:00 p.m. The Immediate Jeopardy was removed on 3/16/22 at 4:05 p.m., but noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. C. Based on observation, interview, and record review, the facility failed to ensure care was provided to maintain the highest practicable well being for 4 of 21 residents reviewed. Physician's orders were not in place for a resident admitted with surgical wounds and dressings on open wounds were not dated, (Resident J, Resident D, Resident E, Resident F) Findings include: A. The clinical record for Resident B was reviewed on 3/9/22 at 11:22 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disorder and respiratory failure. The Admission MDS (Minimum Data Set) assessment, dated 1/1/22, indicated Resident B was cognitively intact. A Nurse Practitioner Note, dated 1/11/22 at 2:32 p.m., indicated Resident B was seen for increased confusion and fever. The Physical Therapist reported Resident B had increased confusion and agitation. The resident requested to go to the hospital. An order to send the resident to the emergency room for evaluation was written. A Nurse's progress note, dated 1/13/22 at 3:49 p.m., indicated Resident B was found unresponsive. Resident B's blood pressure was 80/39 mm/Hg (millimeters/Mercury), temperature 101.2 degrees Fahrenheit, pulse 139 beats per minutes, and the blood sugar was 154. Emergency services were called to transport the resident to the emergency room for evaluation. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 3/9/22 at 3:13 p.m., the Director of Nursing indicated there was no order written to send Resident B to the hospital nor was an order entered into the electronic medical record. The Nurse Practitioner note, dated 1/11/22 at 2:32 p.m., was not actually signed until 1/14/22 at 10:22 a.m., so the staff wouldn't have been aware Resident B needed to be sent to the hospital. During an interview on 3/11/22 at 11:01 a.m., the Nurse Practitioner indicated she had written an order to send Resident B to the Emergency Department and had not reported that to a nurse because it wasn't emergent at that time. The Nurse Practitioner put the order in a mailbox outside the Assistant Director of Nursing's (ADNS) office which was the standard practice used when the Nurse Practitioner wrote new orders for any residents. When the Nurse Practitioner saw him on 1/13/22, she was going to follow up on labs because he was never sent to the hospital as per the 1/11/22 written order. She does not remember Resident B reporting he had refused to go to the Emergency Department nor the staff reporting that Resident B refused to go to the Emergency Department. Resident B should have been sent to the Emergency Department on 1/11/22. During an interview on 3/11/22 at 2:47 p.m., RN (Registered Nurse) 1 indicated she had been working at the facility for several weeks. The Assistant Director of Nursing (ADNS) had been entering the new orders into the electronic medical record and would give a verbal report to the staff to notify them of the new orders. The Nurse Practitioners sometimes entered the orders for themselves, but most of the time it had been the ADNS. During an interview on 3/11/22 at 3:07 p.m., the ADNS indicated she had been entering the new orders for the Nurse Practitioners during the month of January. The Nurse Practitioner's would put the new orders in a mailbox outside her office and then she, the DON, or the Infection Preventionist would enter them into the electronic medical record. They did this because the Nurse Practitioner was not able to sign into the electronic medical record to enter the new orders. She was not aware of an order to send Resident B to the hospital. On 3/11/22 at 2:30 P.M., a Hospital Progress Note, dated 1/13/22, indicated Resident B was admitted with sepsis, respiratory failure, an acute urinary tract infection. On 3/11/22 at 2:30 P.M., a Hospital Discharge Summary, dated 2/8/22, indicated on 1/28/22 Resident B was comfort measures only. Resident B's respirations had ceased. On 3/11/22 at 4:21 p.m., the Administrator provided a copy of a facility policy, titled Physician Orders, dated 8/2010, and indicated this was the current policy used by the facility. A review of the policy indicated .The provider may write the order in the medical record . place orders in electronic medical record . print copy for Physician to sign and place in paper chart unless they are being signed electronically . the nurse that takes the Physician order will be responsible for executing the order or provide for the safe hand-off to the next nurse . contact .outside venders as required to execute the medical order . notify internal staff of changes/updates as appropriate. document contacts in the medical record. B. The clinical record for Resident C was reviewed on 3/11/22 at 12:50 p.m. The diagnoses included, but were not limited to, diabetes mellitus and schizophrenia. The Annual MDS (Minimum Data Set) assessment, dated 12/24/21, indicated Resident C was cognitively intact and had received insulin every day. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Nurse's progress note, dated 2/22/22 at 1:52 p.m. indicated I was informed by the QMA (Qualified Medication Aide) on 700-hallway that [Resident C] was having seizure activities at 0850. I immediately rushed to the room knowing that a QMA was on that hallway. When I got to the room [Resident C] was sitting up in the wheelchair dressed. Both QMA and CNA (Certified Nursing Aide) were in the room. [Resident C] was lethargic but could respond to voices . While observing [Resident C] for seizure activity, I did not see any activity going on. Then I asked the QMA what [Resident C's] blood sugar was. QMA reported that [Resident C's] blood sugar was 70 this morning . when she rechecked the blood sugar, it reads 64. [Resident C's] unresponsiveness continues to worsen. The QMA brought orange juice but [Resident C] was not able to drink. Then I rushed to get glucagon [a prescription medication to treat hypoglycemia] to administer and there is none on the cart or EDK [Emergency Drug Kit] on both sides. Then I called 911. When the ambulance arrived, I reported to them what the situation was and asked for glucagon. During their assessment, [Resident C's] blood sugar went down to 36. [Resident C] was transported to the hospital. The February 2022 MAR (Medication Administration Record) indicated Resident C's blood sugar reading, on 2/22/22 at 7:30 a.m., was 70. During an interview on 3/11/22 at 3:15 p.m., RN (Registered Nurse) 1 indicated she was unable to locate the glucagon for when a resident becomes hypoglycemic. She was unsure where to find the EDK. During an interview on 3/11/22 at 3:30 p.m., LPN (Licensed Practical Nurse) 1 indicated nurses ask each other where to find the glucagon for when a resident's blood sugar declines. LPN 1 was observed to search through the east and west wing medication room refrigerators and was unable to find the glucagon in either refrigerator. During an interview on 3/12/22 at 10:25 a.m., the Director of Nursing indicated the facility did not have standing orders for an emergency reversal medication for hypoglycemia (low blood sugar). A physician's order would be required before the nurse could administer the medication. During an interview on 3/13/22 at 10:00 a.m., UM 1 indicated that if a resident was admitted with insulin orders she would call the physician to see if they would like to add an order for glucagon because a resident's blood sugar could drop with insulin. During an interview on 3/13/22 at 1:54 p.m., the Medical Director indicated that if a nurse would have called and asked for an order for glucagon, he would have given it. On 3/11/22 at 3:00 p.m., the Director of Nursing provided a copy of a facility policy, titled Blood Glucose Point of Care Testing, dated 12/2014, and indicated this was the current policy used by the facility. A review of the policy indicated It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents .Extremely low blood glucose levels (hypoglycemia) may result in confusion, unusual behaviors, coma, and even death if left untreated. C1. During an interview on 3/14/22 at 10:08 A.M., Resident J indicated his surgical wound treatment to his left ankle had not been completed as ordered by the physician when he initially admitted to the facility. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The clinical record for Resident J was reviewed on 3/10/22 at 9:40 A.M. The diagnoses included, but were not limited to, stress fracture of left ankle and fracture of lower left tibia. The Admission MDS (Minimum Data Set) assessment, dated 10/30/21, indicated Resident J was cognitively intact, did have surgical wounds, but did not require surgical wound care. An Initial Admission Evaluation, dated 10/23/21, indicated Skilled services/reason for admission: wound care . skin intact, resident will remain free of skin breakdown .nurse completing this section [the wound nurse]. A hospital discharge summary, dated 10/23/21, indicated collagenase ointment (a prescription ointment used to debride wounds) apply 1 application topically 2 times a day. A Wound Nurse Practitioner Note, dated 10/25/21 at 9:06 A.M., indicated location - left medial ankle .follow surgeon's orders and scheduled follow up appointments-wet to dry dressings daily. A Physician's orders, dated 11/16/21, indicated cleanse left medial foot and lateral ankle with normal saline, apply wet to dry dressing, cover with pad and secure every day shift for wound care with a start date of 11/17/21. The November 2021 TAR (treatment administration record) indicated on 11/17/21 Resident J started receiving the wet to dry dressing to the left foot and ankle that was ordered on 10/25/21. On 3/18/21 at 2:00 P.M., the Activity Director provided a document, titled Resident Council Minutes, dated December 2022. A review of the document indicated concerns with wound care and medication administration were discussed. Residents in attendance for that meeting included, but were not limited to, Resident J, Resident C and Resident F as indicated by the document. During an interview on 3/21/22 at 9:25 A.M., the Wound Nurse indicated she could not explain why the treatment order from 10/25/21 was not entered into the electronic medical record until 11/17/21 because she didn't work for the facility at that time. However, the Initial Admission Evaluation, dated 10/23/21, indicated she completed the skin section of the evaluation. She was able to recall Resident J admitted with an infection in his wounds. On 3/11/22 at 4:21 P.M. The Administrator provided a copy of a facility policy, titled Physician Orders, dated 8/3/2010, and indicated this was the current policy used by the facility. A review of the policy indicated Medical Orders Transcription .the provider may write the order in the medical record .a provider may give a medical order over the phone .verbal orders are accepted but will be input into [the electronic medical record] by the nurse as soon as practicable. The practitioner will need to sign off on these orders . C2. During a random observation on 3/13/22 at 10:00 a.m., Resident D was observed in his room. The resident was lying in his bed. A soiled, undated dressing was noted on his mid-abdomen. The resident was observed to expose the wound. The wound had a moderate amount of thick, dark red, and whitish drainage. During an interview the resident indicated his dressing did not get changed every day. On 3/14/22 at 9:30 a.m., Resident D was observed in his room. An undated dressing was noted on his mid-abdomen. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a wound care observation on 3/15/22 at 10:00 a.m., the Wound Nurse was observed at the resident's bedside. The Wound Nurse removed an undated dressing. During an interview, at that time the Wound Nurse indicated the dressing should be dated at the time the dressing was changed. On 3/15/22 at 10:30 a.m., the clinical record of Resident D was reviewed. The diagnosis included but were not limited to, open wound of abdominal wall. A Quarterly MDS (Minimum Data Set) assessment, dated 2/21/22, indicated Resident D was cognitively intact. A Physician's Order Summary Report, dated March 17, 2022, indicated Cleanse surgical site to mid abdomen with NS [normal saline], pat dry, apply xeroform in wound bed and lastly cover with a bordered gauze Q [every] night shift for surgical wound. A Care Plan, dated 4/30/21 and current through 3/28/22, indicated Resident D was at risk for altered skin integrity related to impaired mobility. The resident had a surgical wound. The interventions included but were not limited to administer treatments as ordered by a medical provider. A Nurse Practitioner note, dated 3/7/22, indicated to encourage nursing staff to change dressings as ordered. A wound evaluation, dated 3/14/22, indicated to change the dressing daily. C3. During an interview on 3/18/22 at 2:30 p.m., Resident E indicated his dressings did not get changed every day as ordered by the physician. On 3/21/22 at 8:30 a.m., the clinical record of Resident E was reviewed. The diagnoses included but were not limited to, acquired absence of right toe and dependence of renal dialysis. The Annual MDS assessment, dated 12/17/21, indicated Resident E was cognitively intact. The physician orders, dated 3/17/22, indicated Right plantar/heel eschar: Cleanse area with wound cleanser or normal saline. Paint the areas with Betadine daily, secure with dry gauze/kerlix daily. During a wound care observation on 3/17/22 at 2:33 p.m., the Wound Nurse was observed completing Resident E's dressing change. The dressing on Resident E's right foot was undated. During an interview at that time, the Wound Nurse indicated the dressing should have been dated. On 3/18/21 at 2:00 P.M., the Activity Director provided a document, titled Resident Council Minutes, dated December 2022. A review of the document indicated concerns with wound care and medication administration were discussed. Residents in attendance for that meeting included, but were not limited to, Resident J, Resident C and Resident F as indicated by the document. C4. During an interview on 3/13/22 at 11:30 a.m., Resident F indicated the areas on his legs were getting worse and sometimes the dressings on this legs do not get changed for days. On 3/15/22 at 2:33 p.m., the clinical record of Resident F was reviewed. The diagnosis included but were not limited to, Type 2 diabetes mellitus with diabetic neuropathy. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Annual MDS assessment, dated 3/12/22, indicated Resident F was cognitively intact. A Physicians Order, with a start date of 12/27/21, indicated to wrap the bilateral lower extremities with kerlix and ace wraps from toes to knees every day for lymphedema. A care plan, undated, indicated Resident F was at risk for further skin breakdown. The interventions included, but were not limited to: evaluate existing wound daily. During a wound care observation on 3/18/22 at 2:00 p.m., the ADON was observed providing wound care. The ADON removed the undated dressing. During an interview at that time, the ADON indicated the dressing should have been dated indicating the date of the previous dressing change. A wound evaluation, dated 3/14/22, indicated to change the dressing daily. On 3/18/22 at 2:15 p.m., a policy/procedure was requested from the ADON for dating the dressing at the time it was changed. On 3/18/21 at 2:00 P.M., the Activity Director provided a document, titled Resident Council Minutes, dated December 2022. A review of the document indicated concerns with wound care and medication administration were discussed. Residents in attendance for that meeting included, but were not limited to, Resident J, Resident C and Resident F as indicated by the document. On 3/21/22 at 4:00 p.m., a policy/procedure for dating dressings was not provided from the facility by the end of the exit date. The Immediate Jeopardy, that began on 1/11/22 and 2/22/22, was removed on 3/16/22 when the facility inserviced the facility staff on following physician's orders and emergency diabetic medications, but the noncompliance remained at the lower scope and severity of no actual harm with potential for more than minimal harm that is not Immediate Jeopardy because a systemic plan of correction had not been developed and implemented to prevent recurrence. This Federal tag is related to Complaint IN00374538. 3.1-37(a)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Homestead Healthcare Center	7465 Madison Ave Indianapolis, IN 46227

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 36746 Based on observation and interview, the facility failed to ensure and environment free from accident hazards for 1 of 21 resident rooms observed. Medications were left at bedside. (Resident E) Finding includes: During initial tour on 3/10/22 at 10:33 a.m., Resident E's room door was observed to be open. The resident was discharged to the hospital. No staff were observed to be in the room. The following was observed: 1. One clear plastic pill cup. The pill cup contained 6 calcium acetate 667 mg (milligram) capsules. 2. One clear plastic pill cup that contained 1 ibuprofen tablet 400 mg (used to treat pain). 3. One box of Fluticasone Nasal spray (used to relieve symptoms of allergies). 4. One clear plastic drinking cup full of sugar packets. The drinking cup included a providone iodine packet (antiseptic used for skin disinfection). 5. A dresser was observed in the room, next to the door. The top drawer of the dresser was unlocked and easily opened. The drawer contained a bisacodyl suppository (used treat constipation) and 6 pouches of providone iodine. 6. A dresser across from the bed was observed to have 3 lidocaine patches (used to treat pain) in the top drawer. The top drawer was unlocked and easily opened. During in interview at that time, the ADON indicated the medication should have been kept behind locked doors. Resident E was sent to the hospital 5 days ago. On 3/10/22 at 1:33 p.m., the DON provided a policy titled Medication Administration, dated 8/3/10, and indicated it was the current policy being used by the facility. A review of the policy indicated .b. vi. Do not leave medication at bedside. 3.1-45(a)(1)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 44849 Based on interview and record review, the facility failed to ensure urinary catheter care was provided for 1 of 2 residents reviewed for catheter care. This resulted in a resident being diagnosed with sepsis and a urinary tract infection. (Resident B) Finding includes: The clinical record for Resident B was reviewed on 3/9/22 at 11:22 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disorder and neurogenic bladder. The Admission MDS (Minimum Data Set) assessment, dated 1/1/22, indicated Resident B was cognitively intact and did not have an indwelling urinary catheter. An Initial Admission Evaluation, dated 12/27/21 at 6:26 p.m., indicated Resident B had a 14f (size) indwelling Foley catheter that was draining clear urine. A Nurse Practitioner Progress Note, dated 1/11/22 at 2:32 p.m., indicated Resident B was seen for increased confusion and fever. The Physical Therapist reported Resident B had increased confusion and agitation. The resident requested to go to the hospital. An order to send the resident to the emergency room for evaluation was written. A Nurse Practitioner Progress Note, dated 1/13/22 at 2:08 P.M., indicated .Resident B had an indwelling Foley catheter and the catheter had been removed three days prior due to irritation. A Nurse's progress note, dated 1/13/22 at 3:49 p.m., indicated Resident B was found unresponsive. Resident B's blood pressure was 80/39 mm/Hg (millimeters/Mercury), temperature 101.2 degrees Fahrenheit, pulse 139 beats per minutes, and the blood sugar was 154. Emergency services were called to transport the resident to the emergency room for evaluation. The clinical record lacked physician's orders for the care and management of the indwelling urinary catheter. The clinical record lacked a care plan for the indwelling urinary catheter. The clinical record lacked documentation that urinary catheter care had been provided. During an interview on 3/11/22 at 9:45 a.m., the DON indicated Resident B should have had physician's orders and a care plan for the urinary catheter. On 3/11/22 at 2:30 p.m., a Hospital Progress Note, dated 1/13/22, indicated Resident B was admitted with sepsis, respiratory failure, an acute urinary tract infection. On 3/11/22 at 2:30 p.m., a Hospital Discharge Summary, dated 2/8/22, indicated on 1/28/22 Resident B was comfort measures only. Resident B's respirations had ceased. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	On 3/14/22 at 10:00 a.m., a urinalysis result, dated 1/17/22, indicated the urinalysis that had been collected on 1/13/22 had greater than 100,000 CFU/ML (colony-forming unit per milliliter) of Proteus vulgaris (bacteria) in the urine. On 3/14/22 at 10:30 a.m., the DON provided a copy of a facility policy, titled Catheter Care, dated 10/13/13, and indicated this was the current policy used by the facility. A review of the policy indicated catheter care is performed at least twice daily on residents that have indwelling catheters, for as long as the catheter is in place .the risk of bacteremia (bacteria in the blood) is 3 to 36 times more likely than residents without an indwelling catheter. This Federal tag relates to Complaint IN00374538. 3.1-41(a)(2)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 45292 Based on interview and record review, the facility failed to ensure nutritional supplements recommended by a dietician were implemented for 1 of 2 residents reviewed for nutrition. (Resident X) Resident X experienced a significant weight loss before intervention was recommended. Finding includes: On 3/11/22 at 10:49 A.M., Resident X's medical record was reviewed. The diagnoses included, but were not limited to, bipolar disorder, Type 2 diabetes mellitus, and generalized muscle weakness. The Annual MDS (Minimum Data Set) assessment, dated 2/15/22, indicated Resident X had moderate cognitive impairment and required set up assistance and supervision for eating. The care plan indicated goals and interventions were in place for increased nutritional risks and that Resident X had a history of weight changes. The weights included, but were not limited to: 3/1/22-108.2 pounds 2/15/22- 105.2 pounds The 2/15/22 weight struck out in the medical record on 2/26/22 as incorrect documentation. 1/2/22-148 pounds 1/1/22-147 pounds The clinical record lacked any other weight documentation from February 2022 through March 2022. A Progress Note, dated 3/4/22, indicated a weight change was recorded. The note included, but was not limited to, a recommendation from the Registered Dietician for Ensure (a nutritional supplement) TID (three times daily) at this time to promote weight maintenance. A review of the current physician orders indicated there were not any current orders for nutritional supplements. On 3/17/22 at 9:30 A.M., an interview with LPN 7 indicated on 2/8/22 Resident X had readmitted after a fall with a fracture. No weight was recorded for resident's readmitted . LPN 7 indicated she would get a current weight on Resident X and also check on nutritional supplement orders. On 3/17/22 at 11:01 A.M., the DON indicated Resident X was reweighed at 110.2 pounds; this was a loss of 37.8 pounds since the 1/2/22 weight, or a 25.5% weight loss. An order for Ensure three times daily was placed in the eMAR (electronic medication administration record) at 10:29 A.M. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Actual harm Residents Affected - Few	On 3/17/22 at 1:35 P.M., a Resident Height and Weight policy, dated 5/19/16, was provided by the DON who indicated this was the policy currently being used. The policy indicated that reweight parameters included a plus or minus of 5 pounds of weight in one week and that this would result in a reweight within 24 hours, validation with nurse for an accurate weight, and the notification of the IDT (interdisciplinary) team, doctor, and family if indicated. On 3/21/22 at 8:47 A.M., an interview with the DON indicated that Resident X should have been reweighed and had orders for Ensure or other nutritional supplements prior to 3/17/22. 3.1-46(a)(2)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 38466 Based on observation, interview, and record review, the facility failed to provide care for a resident's enteral feeding (tube feeding) for 1 of 1 residents reviewed for enteral feeding. The enteral feeding was not administered as ordered and the equipment was not labeled and dated. (Resident N) Findings include: During the initial facility tour on 3/10/22 from 10:10 a.m. to 10:15 a.m., Resident N was observed resting in bed. Next to the bed was an IV pole. Attached to the IV pole was an IV electronic pump, an unlabeled plastic bottle that was 3/4 full of a tan colored liquid, and a clear plastic bag labeled flush bag. The flush bag was observed to be connected to the unlabeled plastic bottle. The unlabeled plastic bottle was connected to a long plastic tube that contained a tan colored liquid and was attached to the IV electronic pump. The IV electronic pump was observed to not be turned to the on position. The tubing was observed to not be attached to Resident N. The flush bag and unlabeled plastic bottle lacked a label to indicate what was contained within the containers, when it was prepared, and who administered the contents. On 3/11/22 from 9:35 a.m. to 9:45 a.m., Resident N was observed resting in bed. Next to the bed was an IV pole. Attached to the IV pole was an IV electronic pump, an unlabeled plastic bottle that was 3/4 full of a tan colored liquid, and a clear plastic bag labeled flush bag. The flush bag was observed to be connected to the unlabeled plastic bottle. The unlabeled plastic bottle was connected to a long plastic tube that contained a tan colored liquid and was attached to the IV electronic pump. The IV electronic pump was observed to not be turned to the on position. The tubing was observed to not be attached to Resident N. The flush bag and unlabeled plastic bottle lacked a label to indicate what was contained within the containers, when it was prepared, and who administered the contents. On 3/12/22 at 9:50 a.m., Resident N was observed resting in bed. Next to the bed was an IV pole. Attached to the IV pole was an IV electronic pump, a 3/4 filled plastic bottle of Jevity 1.2 cal (a prescribed liquid nourishment administered through a tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and medications), and a clear plastic bag labeled flush bag. The flush bag was observed to be connected to the Jevity 1.2 cal plastic bottle. The Jevity 1.2 cal plastic bottle had a long plastic tube that contained a tan colored liquid and was attached to the IV electronic pump. The IV electronic pump was observed to be turned to the off position. The tubing was observed to not be attached to Resident N. The flush bag lacked a label to indicate what was contained within the container, when it was prepared, or who administered the contents. The Jevity 1.2 cal plastic bottle lacked a label to indicated when it was prepared and who administered its contents. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/13/22 at 9:50 a.m., observed Resident N resting in bed. Next to the bed was an IV pole. Attached to the IV pole was an IV electronic pump, a plastic bottle of Jevity 1.2 cal and a clear plastic bag labeled flush bag. The flush bag was observed to be connected to the Jevity 1.2 cal plastic bottle. The Jevity 1.2 cal plastic bottle had a long plastic tube that contained a tan colored liquid and was attached to the IV electronic pump. The IV electronic pump was observed to be turned to the on position, administering 60 ml/hr (milliliter per hour). The tubing was observed to be attached to Resident N's gtube site, located on her abdomen, and 300 ml of the Jevity 1.2 cal had been administered to the resident. On 3/11/22 at 3:01 p.m., Resident N's clinical record was reviewed. The diagnosis included, but were not limited to, dysphagia following cerebral infarction (trouble swallowing after a stroke). The 5 day Minimum Data Set (MDS) assessment, dated 2/24/22, indicated Resident N had a feeding tube. A Physician order, dated 2/19/22, indicated Resident N was prescribed continuous feeding (uninterrupted tube feeding) of Jevity 1.5 cal strength at 60 ml/hour with a flush at 100 ml/hour every 4 hours. Resident N's current care plan, initiated 1/17/22 and current through 4/21/22, indicated [Resident N] has nutritional problem/potential nutrition problem .dx [diagnosis] of stroke, dysphagia, requires gtube [tube feeding] .to meet nutrient needs .enteral nutrient as ordered . During an interview on 3/12/22 at 9:55 a.m., LPN 7 indicated Resident N was to receive Jevity 1.5 cal at 60 ml/hour continuously. LPN 7 indicated the Jevity and flush bag were supposed to be labeled to indicate who administered the contents and when. During an interview on 3/13/22 at 10:00 a.m., the DON indicated Resident N's tube feeding was for Jevity 1.5 cal and she was unsure why the Jevity 1.2 cal was administered. The DON further indicated the Jevity and flush bag were to be labeled to indicate when and who administered the contents. During an interview on 3/18/22 at 11:04 a.m., the DON indicated the facility had one resident who received tube feedings. On 3/14/22 at 11:00 a.m. the DON provided a copy of the Medication Administration policy, dated 12/14/17, and indicated it was the current policy in use by the facility. A review of the policy indicated, .administer medication only as prescribed by the provider . On 3/14/22 at 11:00 a.m., the DON provided a copy of the General Enteral Feeding Guidelines policy, dated 8/12/16, and indicated it was the current policy in use by the facility. A review of the policy indicated, .A physician/provider order is required to include solution, amount, frequency, rate .a licensed nurse will administer nutritional feeding and care of the enteral tube .label .bottles used for tube care with resident's name and the date and specific use . On 3/14/22 at 11:35 a.m., the DON provided a copy of the Medication Storage and Labeling policy, dated 2/2017, and indicated it was the current policy in use by the facility. A review of the policy indicated, . medications and biologicals labeled .be dated . 3.1-47(a)(2)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. 44849 Based on observation, interview, and record review, the facility failed to ensure a PICC (peripherally inserted central catheter) line dressing was changed for 1 of 1 residents reviewed with a PICC line. (Resident K) Finding includes: During an interview on 3/9/22 at 10:15 A.M., Resident K indicated she didn't think her PICC line had been cared for properly. At that time, the PICC line to Resident K's right upper arm was observed with a dressing dated 2/24/22 and the IV (intravenous) tubing was uncapped and plugged into a port on the tubing. During an interview on 3/9/22 at 10:44 A.M., the Unit Manager indicated she was one of the staff that changed PICC line dressings but was unable to indicate how often a PICC line dressing should be changed. During an interview on 3/9/22 at 10:53 A.M., the Wound Nurse indicated PICC line dressings should be changed every 7 days. The dressing should have been changed. The clinical record for Resident K was reviewed on 3/17/22 at 1:26 P.M. The diagnoses included, but were not limited to, diabetes mellitus and infection following a procedure. The Admission MDS assessment, dated 2/23/22, indicated Resident K was cognitively intact. On 3/21/22 at 1:17 P.M., the Regional Nurse provided a copy of a facility policy, titled Pharmscript, dated 2/09, and indicated this was the current policy used by the facility. A review of the policy indicated A sterile end cap must be placed on the end of the intermittent tubing in between administrations. The sterile end cap must be discarded when the tubing is reattached to the catheter .a dressing change must be done every 7 days or sooner if compromised. 3.1-47(a)(2)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. 44849 Based on interview and record review, the facility failed to ensure a physicians orders were obtained for 1 of 21 residents reviewed. Indwelling urinary catheter and oxygen therapy orders were not obtained. (Resident B) Finding includes: The clinical record for Resident B was reviewed on 3/9/22 at 11:22 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disorder and neurogenic bladder. The Admission MDS (Minimum Data Set) assessment, dated 1/1/22, indicated Resident B was cognitively intact, was receiving oxygen therapy, and did not have an indwelling urinary catheter. An Initial Admission Evaluation, dated 12/27/21 at 6:26 p.m., indicated Resident B had a 14f (size) indwelling Foley catheter that was draining clear urine and was receiving 5 liters per minute of oxygen through a nasal cannula. A Nurse Practitioner Progress Note, dated 1/13/22 at 2:08 p.m., indicated Resident B had an indwelling urinary catheter that had been removed three days prior. The clinical record lacked Physician's orders for the care and management of the urinary catheter and oxygen therapy. During an interview on 3/11/22 at 9:45 A.M., the Director of Nursing indicated Resident B should have had physician's orders for the urinary catheter and oxygen therapy. On 3/11/22 at 4:21 P.M., the Administrator provided a copy of a facility policy, titled Physician Orders, dated 8/3/10, and indicated this was the current policy used by the facility. A review of the policy indicated Medical Orders Transcription .the provider may write the order in the medical record .a provider may give a medical order over the phone .verbal orders are accepted but will be input into [the electronic medical record] by the nurse as soon as practicable. The practitioner will need to sign off on these orders . This Federal tag relates to Complaint IN00374538. 3.1-22(c)(1)

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F 0725 Level of Harm - Actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 44849 Based on observation, interview, and record review, the facility failed to ensure sufficient and competent nursing staff was provided. Treatment orders were not in place, appropriate care for a gtube was not provided, dressings were not dated, PICC line dressings were not changed, catheter care was not provided, medications were left in resident rooms, and antibiotics were given longer than prescribed. (Resident B, Resident Y, Resident E, Resident X, Resident M, Resident F, Resident D, Resident K, Resident J, Resident N) Finding includes: 1. During the survey dates of 3/9/22 through 3/21/22 the following interviews were completed. a. The facility does not have enough staff on evenings and weekends. b. The facility does not have enough staff. It takes an hour for call lights to be answered. 2. During an interview on 3/14/22 at 9:10 a.m. the Director of Nursing indicated the facility does not use competencies, instead the facility uses staff in-services for education. 3. On 3/18/21 at 2:00 P.M., the Activity Director provided a documents, titled Resident Council Minutes. A review of the documents indicated long call light times were discussed at the Resident Council Meetings on 1/31/22 and 2/28/22. During Resident Council Meeting on 3/18/22 at 2:15 p.m., the residents indicated the facility does not have enough staff on third shift. 4. The Facility Assessment Tool, dated 10/1/21, indicated: .average daily census 72 . staffing needs .for direct care needs: 3 or 4 Licensed Practical Nurses (LPN) or Registered Nurses (RN) on day shift, 3 or 4 LPN or RN on evening shift, and 2 LPN or RN on night shift. 5. The as worked nursing schedule, dated 2/23/22 to 3/9/22, indicated: a. On 2/23/22, the facility had 1 Licensed Practical Nurse (LPN) that worked day shift, 1 LPN that worked evening shift, and 1 Registered Nurse (RN) that worked night shift. b. On 2/24/22, the facility had 1 LPN that worked day shift, 2 LPN's that worked evening shift, and 1 LPN that worked night shift. c. On 2/25/22, the facility had 1 LPN that worked day shift, 1 RN that worked evening shift, and 1 RN that worked night shift. d. On 2/26/22, the facility had 1 LPN that worked day shift, 1 LPN that worked evening shift, and 1 LPN that worked night shift. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Some	e. On 2/27/22, the facility had 1 LPN that worked day shift, 1 LPN that worked evening shift, and 1 LPN that worked night shift. f. On 2/28/22, the facility had 1 LPN that worked day shift, 2 LPN's that worked evening shift, and 1 RN that worked night shift. g. On 3/1/22, the facility had 2 LPN's that worked day shift, 1 LPN that worked evening shift, and 1 LPN that worked night shift. h. On 3/2/22, the facility had 1 LPN that worked day shift, 1 LPN that worked evening shift, and 1 LPN that worked night shift. i. On 3/3/22, the facility had 1 LPN that worked day shift, 1 LPN and 1 RN that worked evening shift, and 1 RN that worked night shift. j. On 3/4/22, the facility had 2 LPN's that worked day shift, 2 LPN's that worked evening shift, and 1 LPN that worked night shift. k. On 3/5/22, the facility had 1 LPN that worked day shift, 1 LPN and 1 RN that worked evening and night shift. l. On 3/6/22, the facility had 2 LPN's that worked day shift, 1 LPN and 1 RN that worked evening and night shift. m. On 3/7/22, the facility had 1 LPN that worked day shift, 1 LPN and 1 RN that worked evening shift, and 1 RN that worked night shift. n. On 3/8/22, the facility had 1 LPN that worked day shift, 1 LPN that worked evening shift, and 1 LPN that worked night shift. o. On 3/9/22, the facility had 1 LPN that worked day shift, 1 LPN that worked evening shift, and 1 LPN that worked night shift. 6. The lack of sufficient nursing staff resulted surgical dressing changes not being completed. Cross reference F684. 7. The lack of sufficient nursing staff resulted care not being provided for a feeding tube. Cross reference F693. 8. The lack of sufficient nursing staff resulted PICC line dressings not being changed. Cross reference F694. 9. The lack of sufficient nursing staff resulted nutritional supplements not being provided. Cross reference F692. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Some	10. The lack of sufficient nursing staff resulted medications being left in a resident room. Cross reference F689. 11. The lack of sufficient nursing staff resulted a resident receiving unnecessary medications. Cross reference F757. 12. The lack of sufficient nursing staff resulted a lack of urinary catheter care. Cross reference F690. This Federal tag relates to Complaint IN00374538. 3.1-17(a)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 44849 Based on observation and record review, the facility failed to ensure 8 consecutive hours of RN (Registered Nurse) services 7 days a week for 9 of 28 days reviewed. Finding includes: On 3/9/22 between 8:45 A.M. an 9:00 A.M., during the initial facility tour, no RN was observed to be working the resident units. On 3/9/22 at 10:00 A.M., the daily as worked schedule for 3/9/22 indicated there was no RN coverage scheduled for the entire day. On 3/9/22 at 3:00 P.M., the schedule of licensed nurses for 2/10/22-3/9/22 was reviewed. The facility lacked 8 hours of RN coverage on 2/15/22, 2/22/22, 2/24/22, 2/26/22, 3/1/22, 3/2/22, 3/4/22, 3/8/22, and 3/9/22. On 3/9/22 at 3:25 P.M., proof of RN coverage was requested from the Regional Nurse. On 3/21/22 at 4:00 P.M., the facility failed to provide documentation for RN coverage on 2/15/22, 2/22/22, 2/24/22, 2/26/22, 3/1/22, 3/2/22, 3/4/22, 3/8/22 and 3/9/22 by survey exit. 3.1-17(b)(3)

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	155780	A. Building B. Wing	03/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Homestead Healthcare Center	7465 Madison Ave Indianapolis, IN 46227

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 45292 Based on observation, interview, and record review, the facility failed to ensure residents were free from unnecessary medications for 1 of 6 residents reviewed for unnecessary medications. A resident received an antibiotic medication for two weeks beyond the hospital's discharge orders for the antibiotic. (Resident Y) Finding includes: On 3/14/22 at 11:23 A.M., Resident Y's clinical record was reviewed. A Quarterly MDS (Minimum Data Set) assessment, dated 12/29/21, indicated Resident Y was cognitively intact. The Physician's orders included, but were not limited to: Cefuroxime Axetil (an antibiotic medication), 250 mg (milligram) capsules, take one capsule every 12 hours, for infection. There was no end date for the antibiotic A Hospital Discharge note, dated 2/25/22, indicated Resident Y had been admitted and treated for altered mental status and was found to have a UTI (urinary tract infection) on arrival. She was treated at the hospital with 3 days of Cefuroxime Axetil . The note indicated the resident would be sent back to the facility 2 days of antibiotics to complete a 5 day course. The eMAR (electronic medication administration record) was included, but was not limited to: Cefuroxime Axetil 250 mg capsule had been signed out as given twice daily from 2/25/22 until 3/13/22. The 9:00 A.M. dose was documented as given on 3/14/22. On 3/14/22 at 3:11 P.M., during an observation with the ADON, Resident Y's ordered antibiotic medication could not be found in the medication cart. The ADON indicated she would reorder the medication. On 3/15/22 at 8:30 A.M., a progress note dated 3/14/22 at 3:45 P.M. stated, Received new orders to DC [discontinue] Ceftin [Cefuroxime Axetil] due to completion of ATB (antibiotic). New orders have been noted and family aware of ATB [antibiotic] DC [discontinue]. On 3/21/22 at 8:40 A.M., an interview with the DON indicated that Resident Y's antibiotic orders should have been discontinued two days after her readmitted as stated in her hospital discharge orders. On 3/17/22 at 1:35 P.M., a current Medication Administration policy, dated 8/3/10, was provided by the DON who indicated this was the policy currently in use. The policy indicated medication will be administered as prescribed. 3.1-48(a)(2) 3.1-48(a)(4)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 45292 Based on observation, interview, and record review, the facility failed to ensure medications and supplies were stored properly for 2 of 2 medication carts observed, 1 of 1 Central Storage Room, and 1 of 1 medication rooms observed. Loose pills were observed in the medication carts, supplies were expired, and resident enteral nutrition was expired. (200 Hall Medication Cart, 600 Hall medication cart, Central Supply Storage Room, [NAME] Side Medication Room) Findings include: 1. On 3/18/22 at 10:28 A.M., the 200 Hall Medication Cart drawers were observed to have the following pills loose and unlabeled in the bottoms of the drawers where resident medications were kept. The pills observed included: 3 white round pills, 1 pink round pill, 1 green round pill, 1 beige capsule, and one blue and white capsule. Eighteen residents received their medications from this medication cart on the 200 Hall. 2. On 3/18/22 at 10:45 A.M., the 600 Hall Medication Cart drawers were observed to have the following pills loose and unlabeled in the bottoms of the drawers where resident medications were kept. The pills observed included: 2 beige capsules, 1 oval white pill, 2 blue and white capsules, 4 round white pills, 2 blue round pills, 2 beige round pills, 1 red round pill, 1 orange round pill, 1 yellow round pill, 1 beige oval pill, and 2 round pale green pills. One side drawer was noted to have spilled medication powder and residue. Seventeen residents received their medications from this medication cart on the 600 Hall. On 3/18/22 at 10:55 A.M., an interview with the DON (Director of Nursing) indicated that the medication carts are supposed to be cleaned daily on night shift and as needed and that loose medications should have been properly discarded. 38466 3. On 3/12/22 at 9:50 a.m., observed Resident N resting in bed. Next to the bed was an IV pole. Attached to the IV pole was an IV electronic pump, a 3/4 filled plastic bottle of Jevity 1.2 cal (a prescribed liquid nourishment administered through a tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and medications), and a clear plastic bag labeled flush bag. The flush bag was observed to be connected to the Jevity 1.2 cal plastic bottle. The Jevity 1.2 cal plastic bottle had a long plastic tube that contained a tan colored liquid and was attached to the IV electronic pump. The IV electronic pump was observed to be turned to the off position. The tubing was observed to not be attached to Resident N. Use by 12/1/21 was printed on the Jevity 1.2 cal bottle. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. On 3/12/22 at 10:00 a.m., during a tour of the Central Supply Storage room with the DON. The DON was observed to open 4 boxes of Jevity 1.5 cal which contained 6 unopened bottles of Jevity. Each bottle had use by 12/1/21 printed on the bottle. During an interview at that time, the DON indicated on 2/2/22 the facility supplier delivered the Jevity 1.5 cal boxes. The Central Supply Coordinator was to verify the product's use by date at the time of delivery from the supplier. Additionally, the nurses were to verify the status of the use by date before administering any medications or tube feedings. 36746 5. During medication storage room observation, on 3/18/22 at 10:42 a.m., the following expired medications and medical supplies in the [NAME] Side Medication Room were observed: a. #1 BD 20 gauge insyte autoguard IV (intravenous) catheter (a devise used to draw blood and give treatments.), the label indicated an expiration date of 4/30/19. b. #1 BD 20 gauge insyte autoguard IV catheter, the label indicated an expiration date of 3/31/20. c. #1 BD 24 gauge IV catheter, the label indicated an expiration date of 11/30/20. d. #30 BD Safetyglide needles 21 gauge, the label indicated an expiration date of 10/31/21. e. #86 Hemocult single slides (A test used to screen for colorectal cancer), the label indicated an expiration date of 11/2020. f. #90 Hemocult single slides with a label that indicated an expiration date of February 2022. g. #150 Blood Glucose Test strips (used to determine a high or low blood sugar level), with a label that indicated an expiration date of 6/30/21. h. #3 Hydrophilic dressing foam (used on wounds to keep the area moist), with a label that indicated an expiration date of October 2021. During an interview at that time, the ADON indicated the expired medications and medical supplies should have been pitched at the time they had expired. On 3/18/22 at 11:35 A.M., a current Medication Storage and Labeling policy, dated February 2017, was provided by the DON who indicated this was the policy being used. The policy indicated that all medications and biologicals should be stored and labeled properly. On 3/21/22 at 11:09 a.m., the DON provided a policy titled Medication Administration, dated 8/3/10 and indicated it was the current policy being used by the facility. A review of the policy indicated .ii. Check expiration dates 1. Do not administer expired medications. 3.1-25(o)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38466 Based on observation, interview, and record review, the facility failed to serve food in a sanitary manner during 4 of 4 observations where staff's hair was uncovered. (Dietary Manager, Dietary Aide 1, CNA 2) Findings includes: 1. During the initial kitchen tour on 3/10/22 from 3:35 p.m. to 3:55 p.m., the DM (Dietary Manager) was observed walking through out the kitchen where the evening meal was being prepared. The DM was observed wearing a surgical face mask. Between the DM's ears and the surgical face mask area, facial hair, 1/2 inch in length, was visible and was observed to not be covered. At the chin area, below the surgical face mask facial hair, 2 inches in length, was observed to not be covered. 2. During a follow-up kitchen tour on 3/11/22 from 10:45 a.m. to 11:05 a.m., the following was observed: a. The DM was observed walking near the steamtable area where the noon meal foods were kept. The DM then began placing the lids onto the resident's plated noon meal foods. The DM was observed wearing a surgical face mask. Between the DM's ears and the surgical face mask area, facial hair, 1/2 inch in length, was visible and was observed to not be covered. At the chin area, below the surgical face mask, facial hair, 2 inches in length, was observed to not be covered. b. Dietary Aide 1 was observed near the steamtable area where the noon meal foods were kept. Dietary Aide 1 began to prepare the resident's food trays. Dietary Aide 1 was observed wearing a surgical face mask. Between the Dietary Aide 1's ears and the surgical face mask area, facial hair, 3/4 inch in length, was visible and was observed to not be covered. At the chin area, below the surgical face mask facial hair, 1 inch in length, was observed to not be covered. 3. During a follow-up kitchen tour on 3/11/22 from 12:30 p.m. to 12:37 p.m., the following was observed: a. The DM was observed walking near the steamtable area where the noon meal foods were kept. At the grill, next to the steamtable, the DM prepared a grilled cheese sandwich for a resident. The DM was observed wearing a surgical face mask. Between the DM's ears and the surgical face mask area, facial hair, 1/2 inch in length, was visible and was observed to not be covered. At the chin area, below the surgical face mask, facial hair, 2 inches in length, was observed to not be covered. b. Dietary Aide 1 was observed near the steamtable area where the noon meal foods were kept. Dietary Aide 1 then walked to the dish machine and began washing dishes. Dietary Aide 1 was observed wearing a surgical face mask. Between the Dietary Aide 1's ears and the surgical face mask area, facial hair, 3/4 inch in length, was visible and was observed to not be covered. At the chin area, below the surgical face mask, facial hair, 1 inch in length, was observed to not be covered. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. CNA (Certified Nursing Assistant) 2 entered the kitchen area. While conversing with the dietary staff, CNA 2 walked to the steamtable where the noon meal foods were kept and stood at the grill area where a resident's grilled cheese sandwich was being prepared. CNA 2's hair, 6 inches in length, was observed to not be covered. 4. During a follow-up kitchen tour 3/14/22 from 9:15 a.m. to 9:20 a.m., the following was observed: a. Dietary Aide 1 was observed walking through out the kitchen near where the noon meal was being prepared, then walked to the dish machine and began washing dishes. Dietary Aide 1 was observed wearing a surgical face mask. Between the Dietary Aide 1's ears and the surgical face mask area, facial hair, 3/4 inch in length, was visible and was observed to not be covered. At the chin area, below the surgical face mask, facial hair, 1 inch in length, was observed to not be covered. During an interview at that time, Dietary Aide 1 indicated the facial hair under the chin was to be covered but he was unsure if the hair in front of the ears was to be covered. b. The DM was observed walking through out the kitchen area near where the noon meal was being prepared. The DM was observed wearing a surgical face mask. Between the DM's ears and the surgical face mask area, facial hair, 1/2 inch in length, was visible and was observed to not be covered. At the chin area, below the surgical face mask facial hair, 2 inches in length, was observed to not be covered. During an interview on 3/14/22 at 9:25 a.m., the DM indicated while in the kitchen, all dietary staff's hair, including facial hair, was to be covered. On 3/15/22 at 9:05 a.m., the DM provided a copy of the Staff Attire policy, date 9/2017, and indicated it was the current policy in use by the facility. A review of the policy indicated, .all staff members will have their hair off the shoulders, confined in a hair net or cap, and facial hair properly restrained . On 3/14/22 at 2:00 p.m., a review of the Retail Food Establishment Sanitation Requirements Title 410 IAC 7-24, effective November 13, 2004, indicated, .food employees shall wear hair restraints such as .hair coverings or nets, beard restraints .that are designed and worn to wear effectively keep their hair from contacting .exposed food . 3.1-21(i)(2) 3.1-21(i)(3)

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F 0814 Level of Harm - Potential for minimal harm Residents Affected - Many	Dispose of garbage and refuse properly. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38466 Based on observation, interview, and record review, the facility failed to ensure the dumpster's sliding side panel door and top lid were kept closed when not in use for 3 of 3 observations. Findings include: During the initial kitchen tour with the Dietary Manager (DM) on 3/10/22 from 4:00 p.m. to 4:05 p.m., the dumpster site area was observed, located near the east wing's north exit door, which contained 2 individual dumpsters. Multiple [NAME] were observed near the dumpster site area. The dumpster, on the left, had 2 top lids and 2 sliding side panel doors. The top lid and sliding side panel door, on the left side of the dumpster, was observed to be not closed. No staff members were observed in the area at that time. During an interview at that time, the DM indicated all dumpster lids and doors were to be kept closed when not in use. On 3/11/22 from 5:10 p.m. to 5:15 p.m., the dumpster site area was observed, located near the east wing's north exit door, which contained 2 individual dumpsters. Multiple [NAME] were observed near the dumpster site area. The dumpster, on the left, had 2 top lids and 2 sliding side panel doors. The top lid, on the right side of the dumpster, was observed to not be closed and filled trash bags were partially hanging outside of the dumpster. No staff members were observed in the area at that time. On 3/14/22 from 4:00 p.m. to 4:05 p.m., the dumpster site area was observed, located near the east wing's north exit door, which contained 2 separate dumpsters. Multiple [NAME] were observed near the dumpster site area. The dumpster, on the left, had 2 top lids and 2 sliding side panel doors. The top lid, on the right side of the dumpster, was observed to not be closed and filled trash bags were visible inside the dumpster. No staff members were observed in the area at that time. On 3/15/22 at 9:05 a.m., the DM provided a copy of the Dispose of Garbage and Refuse policy and indicated it was the current policy in use by the facility. A review of the policy indicated, .all garbage and refuse will be collected and disposed of in a safe and efficient manner the dining services director will ensure that . appropriately lined containers are available within the food services area for disposal of garbage or other refuse .appropriate lids are provided for all containers . On 3/14/22 at 10:40 a.m., a review of the Retail Food Establishment Sanitation Requirements Title 410 IAC 7-24, effective November 13, 2004, indicated, .receptacles and waste handling units for refuse, recyclables and returnables shall be kept covered with tight-fitting lids or doors if kept outside . 3.1-21(i)(2) 3.1-21(i)(5)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 38466 Based on interview and record review, the facility failed to thoroughly conduct and document a facility-wide assessment based on the residents needs and the required resources to provide the care and services needed. This had the potential to affect 75 of 75 residents residing in the facility. Finding includes: On 3/18/22 at 3:00 p.m., the Facility Assessment Tool guide was reviewed. A review of the tool indicated, . Requirement: Nursing Facilities will conduct, document, and annually review a facility-wide assessment, which includes both their resident population and the resources the facility needs to care for their residents . Purpose: The purpose of the assessment is to determine what resources are necessary to care for residents competently during both day to day operations and emergencies. On 3/21/22 at 2:35 p.m., the Administrator provided a copy of the Facility Assessment Tool for Homestead Healthcare Center, dated 11/2020 through 10/2021, and indicated it was the current and completed facility assessment in use by the facility. A review of the document included the following: -The Facility Assessment was completed on 10/1/21. Staff members involved in the completion of the Facility Assessment included the Administrator, Director of Nursing, Governing Body Representative, Human Resources Director, Business Office Manager, Medical Director, and the Admission Director. -Section 3.3 lacked documented description for how you determine and review individual staff assignments for coordination and continuity of care for residents within and across the staff assignments. -Section 3.4 lacked documented description for how staff training/education and competencies that are necessary to provide the level and types of support and care needed for the resident population. -Section 3.5 lacked documented description for how you for evaluate what policies and procedures may be required for the provision of care and how you ensure those meet current professional standards of practice. -Section 3.6 lacked documented description of the plan to recruit and retain enough medical practitioners (e. g. physicians, nurse practitioners) who are adequately trained and knowledgeable in the care of the resident population, including how you will collaborate with them to ensure that the facility has appropriate medical practices for the needs and scope of your population. -Section 3.7 lacked documented description for how management and staff familiarize themselves with what they should expect from medical practitioners and other healthcare professionals related to standards of care and competencies necessary to provide the level and types of support and care needed for the resident population. -Section 3.9 lacked documented .lists of contracts, memoranda of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies. (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Section 3.10 lacked documented .list of health information technology resources, such as systems for electronically managing resident records and electronically sharing information with other organizations. -Section 3.11 lacked documented evaluation process for the .infection prevention and control program that included effective systems for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for residents, staff, volunteers, visitors, and other service providers under contractual arrangement that meet accepted national standards. -Section 3.12 lacked documented .facility-based and community-based risk assessment, utilizing an all-hazards approach (an integrated approach focusing on capacities and capabilities critical to preparedness for a full spectrum of emergencies and natural disasters). During an interview on 3/10/22 at 9:30 a.m., the Administrator indicated the facility census was 75. On 3/11/22 at 1:15 p.m., the Administrator provided a copy of the QAPI (Quality Assurance Performance Improvement) Plan, dated 5/30/19, and indicated it was the current policy in use by the facility. A review of the document indicated, .to identify opportunities for improvement, address gaps in systems or processes, develop and implement an improvement or corrective plan and continuously monitor effectiveness of interventions .It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. Safety of residents, staff and visitors is a primary focus of the facility. Regulations require that the facility have a on-going quality assurance process improvement plan to monitor the quality of resident care .

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 45292 Based on observation, interview, and record review, the facility failed to keep an accurate medical record for 2 of 21 residents reviewed for resident medical records. A resident had an antibiotic medication signed off as given in excess of the number of doses available and a resident had discrepancies noted between the electronic medication administration record (eMAR) and the physical narcotic sign-out sheets on paper. (Resident 56, Resident Y) Findings include: 1. On 3/14/22 at 11:23 A.M., Resident Y's clinical record was reviewed. A Quarterly MDS (Minimum Data Set) assessment, dated 12/29/21, indicated Resident Y was cognitively intact. The Physician's orders included, but were not limited to: Cefuroxime Axetil (an antibiotic medication), 250 mg (milligram) capsules, take one capsule every 12 hours, for infection. There was no end date for the antibiotic A Hospital Discharge note, dated 2/25/22, indicated Resident Y had been admitted and treated for altered mental status and was found to have a UTI (urinary tract infection) on arrival. She was treated at the hospital with 3 days of Cefuroxime Axetil . The note indicated the resident would be sent back to the facility 2 days of antibiotics to complete a 5 day course. The eMAR (electronic medication administration record) was included, but was not limited to: Cefuroxime Axetil 250 mg capsule had been signed out as given twice daily from 2/25/22 until 3/13/22. The 9:00 A.M. dose was documented as given on 3/14/22. On 3/14/22 at 3:11 P.M., during an observation with the ADON, Resident Y's ordered antibiotic medication could not be found in the medication cart. The ADON indicated she would reorder the medication. On 3/15/22 at 11:26 A.M., the DON provided the following clarifications from the pharmacy. The pharmacy indicated they sent 4 doses of Resident Y's antibiotic on 2/26/22, 4 doses on 3/2/22, 4 doses on 3/6/22, and 4 doses on 3/7/22 for a total of 16 doses sent. No doses of the antibiotic were noted to be removed from the back up pharmacy supply kit for Resident Y. The total number of doses signed out as given until the 3/14/22 discontinue date was 35 doses given. On 3/21/22 at 8:40 A.M., an interview with the DON indicated, when asked about the number of doses of antibiotic given and the number of times it was signed out for the duration of the active order, that staff had been signing it out at times without administerting the medication. 2. On 3/11/22 at 11:15 A.M., Resident 56's medical record was reviewed. An Admission MDS (Minimum Date Set) assessment, dated 2/2/22 indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, CVA affecting the left/dominant side, high blood pressure, and COPD (chronic obstructive pulmonary disorder). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/16/22 at 9:20 A.M., Resident 56's sign-out sheets for her narcotic pain pill indicated that she received her PRN (as needed; resident may have it as needed for pain within order parameters) Hydrocodone-Acetaminophen (an opoid pain pill) 5/325 mg (milligram) tablet at least once daily from 2/3/22 through 2/8/22 and from 2/10/22 to 2/27/22. On 3/16/22 at 9:40 A.M., Resident 56's eMAR for the hydrocodone-acetaminophen order indicated 10 days where she did not receive a tablet of her PRN pain medication at least once daily from 2/3/22 through 2/27/22 including; 2/3/22, 2/5/22, 2/6/22, 2/9/22, 2/10/22, 2/14/22, 2/15/22, 2/20/22, 2/21/22, and 2/23/22. On 3/18/22 at 9:42 A.M., a comparison of Resident 56's paper sign-out sheets for the Norco 5/325mg order and the eMAR for the Norco 5/325mg order indicated there were 17 instances of the paper sign-out sheet having more Norco tabs signed out than were marked as given in the eMAR. The discrepancies are as follows for Resident 56's Norco 5/325mg 1 tab every 6 hours PRN order: -On 2/3/22 the narcotic sign-out sheet indicated 2 doses were given and the eMAR indicated none were given, -On 2/4/22 the narcotic sign-out sheet indicated 3 doses were given and the eMAR indicated 1 was given, -On 2/5/22 the narcotic sign-out sheet indicated 3 doses were given and the eMAR indicated none were given, -On 2/6/22 the narcotic sign-out sheet indicated 3 doses were given and the eMAR indicated none were given, -On 2/7/22 the narcotic sign-out sheet indicated 2 doses were given and the eMAR indicated 1 was given, -On 2/10/22 the narcotic sign-out sheet indicated 1 dose was given and the eMAR indicated none were given, -On 2/11/22 the narcotic sign-out sheet indicated 2 doses were given and the eMAR indicated 1 was given, -On 2/13/22 the narcotic sign-out sheet indicated 3 doses were given and the eMAR indicated 2 doses were given, -On 2/14/22 the narcotic sign-out sheet indicated 3 doses were given and the eMAR indicated none were given, -On 2/15/22 the narcotic sign-out sheet indicated 1 dose was given and the eMAR indicated none were given, -On 2/16/22 the narcotic sign-out sheet indicated 2 doses were given and the eMAR indicated 1 dose was given, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155780	A. Building B. Wing	03/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Homestead Healthcare Center	7465 Madison Ave Indianapolis, IN 46227

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 2/18/22 the narcotic sign-out sheet indicated 2 doses were given and the eMAR indicated 1 dose was given, -On 2/19/22 the narcotic sign-out sheet indicated 3 doses were given and the eMAR indicated 1 dose was given, -On 2/20/22 the narcotic sign-out sheet indicated 2 doses were given and the eMAR indicated none were given, -On 2/21/22 the narcotic sign-out sheet indicated 2 doses were given and the eMAR indicated none were given, -On 2/23/22 the narcotic sign-out sheet indicated 2 doses were given and the eMAR indicated none were given, -On 2/24/22 the narcotic sign-out sheet indicated 3 doses were given and the eMAR indicated 1 dose was given. On 3/17/22 at 1:35 P.M., a current Medication Administration policy, dated 8/3/10 was provided by the DON who indicated this was the policy being used. A review of the policy indicated, under section VI. Narcotic that staff are to a. Sign out narcotic controlled substance[s] from narcotic count card when removed and to b. Record narcotic in MAR. On 3/18/22 at 9:50 A.M., an interview with the Regional Nurse indicated that the discrepancy was a documentation issue and that staff should be signing it in both the eMAR and on the narcotic sign-out sheets. 3.1-50(a)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 36746 Based on observation, interview, and record review, the facility failed to ensure COVID-19 infection control measures were implemented to prevent the potential spread of COVID-19 for 1 of 1 residents who received aerosol generating procedures. (Resident 66) Findings include: On 3/9/22 from 11:24 a.m. until 11:29 a.m., Resident 66 was observed in his room with a c-pap (continuous positive airway pressure) mask on his face. The mask was observed to have aerosol mist coming from the face mask. Resident 66's room mate (Resident 41) was present on his side of the shared room watching television. The privacy curtain, between Resident 66 and Resident 41, was observed to be open, exposing Resident 41 to the aerosol mist from Resident 66's C-PAP. No signage was observed to be on the residents door to indicate a type of isolation and instructions. No PPE (personal protective equipment) was observed outside of the residents door. During an interview at that time, the resident indicated he can use the C-PAP anytime he wants and uses it all the time. During an interview on 3/9/22 at 11:29 a.m., the Wound Nurse indicated Resident 66 should have an isolation sign on his door and PPE outside of this door. On 3/10/22 at 11:10 a.m., the record of Resident 66 was reviewed. The diagnosis included but were not limited to, chronic obstructive pulmonary disease and obstructive sleep apnea. A Physicians order summary, dated March 2022, indicated CPAP Rate 10 with Oxygen at 6 liters at night and as needed, with a start date of 9/8/21 for the diagnosis obstructive sleep apnea. On 3/11/22 from 10:30 a.m. until 10:45 a.m., Resident 66 was observed in his room with c-pap face mask on his face. The mask was observed to have aerosol mist coming from the face mask. Resident 66's roommate was present in the room. The privacy curtain between Resident 66 and Resident 41 was observed to not be pulled shut, exposing Resident 41 to the aerosol mist from Resident 66's C-PAP. During an interview on 3/11/22 at 10:45 a.m., the Assistant Director of Nursing indicated she was not sure if the resident should be in isolation. On 3/12/22 at 9:00 a.m., the Director of Nursing provided a policy titled Policies and Standard Procedures, dated 9/2/2020, and indicated it was the current policy being used by the facility. A review of the policy indicated, **Higher risk Exposure: refers to exposure of .aerosol-generating procedure. This can occur when staff do not wear adequate personal protective equipment during care . 3.1-18(b)(1)